

**Cascadia Eye Care
Welcome To Our Office**

Welcome to Cascadia Eye Care. Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you place in us. Please print this form and take a moment to complete the following information and bring it with you to your appointment. We look forward to seeing you.

Mr. Mrs. Miss Ms. Male Female

First Name MI Last Name Preferred Name

Street Address City State Zip

Social Security Number Date of Birth Home Phone – Include Area Code Work Phone Cell Phone

Email Address Spouse or Parent (s) Name Person Responsible for Account

Emergency Contact Emergency Phone

How were you referred to our office? Patient (Please Name) _____

Last Name First Name MI

Phone Book School Advertisement Insurance Listing Insurance Website Location Internet
 Website Other _____ Doctor (Please Name) _____

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company City State Zip

M F _____
Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship to Insured: Self Spouse Child Other
Patient Status: Single Married Other
 Full Time Student Part Time Student Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company City State Zip

M F _____
Insured's First Name MI Insured's Last Name

Insured's Identification Number Group Number Insured's Date of Birth

Patient Relationship To Insured: Self Spouse Child Other

Please Read:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and materials are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

I understand that my vision benefit and/or medical insurance provider will be billed and that payment is to be made directly to Cascadia Eye Care. I understand that all benefits quoted to me are not a guarantee of payment by my vision benefit or medical insurance provider as insurance companies do not guarantee the information given and that final determination can only be made when the claim is processed.

Signature Date

**Cascadia Eye Care
Medical History Questionnaire**

Please print off and take a moment to fill out this portion of the Medical History Questionnaire. Bring this completed form as well as the completed Welcome to the Office Form with you to your appointment. Again, we look forward to seeing you.

Patient Name _____ Date _____

PRIMARY CARE PHYSICIAN:

Doctor's Name _____ Phone # _____

SOCIAL HISTORY:

Current Occupation _____ Years _____ Employer _____

SPECTACLE LENS HISTORY:

Do you use a computer? yes no How many hours/day? _____

Do you drive? yes no Mileage to work each way? _____

Do you have visual difficulty when driving? yes no

Do you have problems with night vision? yes no

Do you currently wear glasses? yes no Since _____

Do you have glare problems? yes no

Glasses Owned:

Single Vision Bifocals Trifocals Backup Safety Sports Progressive

Have you had trouble in the past with glasses? yes no (If yes, explain) _____

Do you wear sunglasses? yes no

Are your sunglasses your current prescription? yes no

SPECIAL EYEWEAR NEEDS:

Computer (special prescriptions, special anti-glare tints or coatings)

Occupational (mechanics, plumbers, pilots etc.)

Safety Glasses (gardening, woodworking, welding etc.)

Sports (racquet sports, motorcycle, skiing, swimming etc.)

Hobbies (sewing, playing and or reading music, etc.)

SOCIAL HISTORY:

Do you use nutritional supplements (vitamins etc.)? yes no

Do you engage in regular exercise? yes no

Do you use Illegal Drugs: yes no

Do you drink alcohol?

If yes, how much/often no Occasional 1 per day 2-3 per day 4+ per day

Do you smoke?

If yes, how much/often no Occasional 1/2 pack/ day 1 pack/day 1 + pack

Method of Tobacco Intake: Smoking Chewing

Hobbies/ Interests: _____

Spouse's Name _____

Name Of Children At Home and Ages: _____
